Jurisdictional Documents and Notices

Civil Action Number: 2:17-01146
Claimant: Trish Ann Fontana
Account Number: 197-56-3849

Exhibits

Exhibit No.	Description	Page No.	No. of Pages
1B	Personal Decision Notice - Title II Notice of Disapproved Claim, dated 07/10/2013	72-76	5
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DATE: April 18, 2018

The documents and exhibits contained in this administrative record are the best copies obtainable.

Social Security Administration
Retirement, Survivors, and Disability Insurance
Notice of Disapproved Claim

Trish Ann Fontana
3130 Glendale Avenue
Pittsburgh, PA 15227

Date: 07/10/2013

Claim Number:
197-56-3849

We are writing about your claim for Social Security disability benefits. Based on a review of your health problems you do not qualify for benefits on this claim. This is because you are not disabled under our rules.

The Decision On Your Case

The following reports were used to decide your claim. Additional reports were not needed because the ones shown below had enough information to evaluate your condition.

1. Jefferson Regional Med Ctr, response received 05/08/13
2. Jory Richman, M.D., response received 05/29/13
3. Gregg Weidner, M.D., response received 05/13/13
4. UPMC Mercy, response received 05/18/13
5. Gregg G. Weidner, M.D., response received 05/27/13
6. UPMC South Side Hospital, response received 05/18/13
7. David J. Mance, D.P.M., response received 05/21/13
8. Jrmc Diagnostics, response received 05/13/13
9. Robert Hoffman, M.D., consultative examination report received 06/26/13

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affects your ability to work.

You said that you are unable to work because of the following conditions: ruptured disc, herniated disc in lower back, herniated cervical disc, sciatica and numbness in legs. Medical findings reveal degenerative changes in your back. However, you maintain adequate function, mobility and strength. You experience pain, but the evidence shows that you are able to stand, walk, lift and carry. You have some limitations in your activities. However, the severity of your condition does not totally disable you. We do not have sufficient vocational information to determine whether you can perform any of your past relevant work. However, based on the evidence in file, we have determined that you can adjust to other work.

Please See Next Page

If your condition gets worse and keeps you from working, write, call or visit any Social Security office about filing another application.

About The Decision

Doctors and other trained staff looked at this case and made this decision. They work for the state but used our rules.

Please remember that there are many types of disability programs, both government and private, which use different rules. A person may be receiving benefits under another program and still not be entitled under our rules. This may be true in this case.

The Disability Rules

You must meet certain rules to qualify for disabled worker's Social Security benefits. You must have the required work credits and your health problems must:

- keep you from doing any kind of substantial work (described below), and
- last, or be expected to last, for at least 12 months in a row, or result in death.

Information About Substantial Work

Generally, substantial work is physical or mental work a person is paid to do. Work can be substantial even if it is part-time. To decide if a person's work is substantial, we consider the nature of the job duties, the skills and experience needed to do the job, and how much the person actually earns.

Usually, we find that work is substantial if gross earnings average over $1040 per month after we deduct allowable amounts. This monthly amount is higher for Social Security disability benefits due to blindness.

A person's work may be different than before his/her health problems began. It may not be as hard to do and the pay may be less. However, we may still find that the work is substantial under our rules.

If a person is self-employed, we consider the kind and value of his/her work, including his/her part in the management of the business, as well as income, to decide if the work is substantial.

Other Benefits

Based on the application you filed, you are not entitled to any other benefits besides those you may already be getting. In the future, if you think you may be entitled to benefits, you will need to file again.

If You Disagree With The Determination

If you disagree with this determination, you have the right to request a hearing. We will review your case and consider any new facts you have. A person who has not seen your case before will look at it.

- You have 60 days to ask for a hearing.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show that you did not get it within the 5-day period.
- You must have a good reason for waiting more than 60 days to ask for an appeal.
- You have to ask for a hearing in writing. We will ask you to complete a form HA-501-U2, called "Request for Hearing". You may contact one of our offices or call 1-800-772-1213 to request this form. Or you may complete this form online at http://www.socialsecurity.gov/disability/appeal. Contact one of our offices if you want help.
- In addition, you should complete a "Disability Report-Appeal" to tell us about your medical condition since you filed your claim. You may contact one of our offices or call 1-800-772-1213 to request this form. Or, you may complete this report online after you complete the online Request for Hearing.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your Social Security Claim." It contains more information about the hearing.

How The Hearing Process Works

After we send your case for a hearing, an Administrative Law Judge (ALJ) will mail you a letter at least 20 days before the hearing to tell you its date, time and place. The letter will explain the law in your case and tell you what has to be decided. Since the ALJ will review all the facts in your case, it is important that you give us any new facts as soon as you can.

The hearing is your chance to tell the ALJ why you disagree with the decision in your case. You can give the ALJ new evidence and bring people to testify for you. The ALJ also can require people to bring important papers to your hearing and give facts about your case. You can question these people at your hearing.

It Is Important To Go To The Hearing

It is very important that you go to the hearing. If for any reason you can't go, contact the ALJ as soon as possible before the hearing and explain why. The ALJ will reschedule the hearing if you have a good reason. If you don't go to the hearing and don't have a good reason for not going, the ALJ may dismiss your request for a hearing.

New Application

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with this decision and you file a new application instead of appealing:

- you might lose some benefits, or not qualify for any benefits, and
- we could deny the new application using this decision, if the facts and issues are the same.

So, if you disagree with this decision, you should ask for an appeal within 60 days.

If You Want Help With Your Appeal

You can have a friend, lawyer, or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it. And if you hire a lawyer, we will withhold up to 25 percent of any past due Social Security benefits to pay toward the fee.

Family Benefits

If you have a spouse or child we cannot pay them benefits unless you are entitled to Social Security benefits.

If You Have Any Questions

If you have any questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at (888) 717-1525. We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

650 Washington Rd Suite 120
Pittsburgh, PA 15228-0000

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Social Security Administration

Enclosure: SSA Pub. No. 64-088

SSA P443 (A34)

NH 197-56-3849

UNIT: LINOHA

TRISH ANN FONTANA
3130 GLENDALE AVE
PITTSBURGH PA 15227

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

On September 13, 2013, we talked with you and completed your REQUEST FOR HEARING for SOCIAL SECURITY BENEFITS. We stored your REQUEST FOR HEARING information electronically in our records and attached a summary of your statements.

What You Need To Do

- Review your REQUEST FOR HEARING to ensure we recorded your statements correctly.
- If you agree with all your statements, you may retain the REQUEST FOR HEARING for your records.
- If you disagree with any of your statements, you should contact us within 10 days after the date of this notice to let us know.

MY NAME IS TRISH ANN FONTANA.

MY SOCIAL SECURITY NUMBER IS 197-56-3849.

I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I DISAGREE WITH THE DETERMINATION MADE ON MY CLAIM FOR DISABILITY-WORKER OR CHILD BENEFITS BECAUSE THE LOWER DECISION IS INCORRECT.

I AM SUBMITTING ADDITIONAL EVIDENCE WITH THIS REQUEST.

I WISH TO APPEAR AT A HEARING. I UNDERSTAND THAT AN ADMINISTRATIVE LAW JUDGE OF THE OFFICE OF DISABILITY ADJUDICATION AND REVIEW WILL BE APPOINTED TO CONDUCT THE HEARING OR OTHER PROCEEDINGS IN MY CASE. I ALSO UNDERSTAND THAT THE ADMINISTRATIVE LAW JUDGE WILL SEND ME NOTICE OF THE TIME AND PLACE OF A HEARING AT LEAST 20 DAYS BEFORE THE DATE SET FOR A HEARING.

IT COULD BE ESPECIALLY USEFUL IN MY CASE SINCE THE ADMINISTRATIVE LAW JUDGE WOULD HAVE AN OPPORTUNITY TO HEAR AN EXPLANATION AS TO HOW MY IMPAIRMENTS PREVENT ME FROM WORKING AND RESTRICT MY ACTIVITIES.

NH 197-56-3849

I AM REPRESENTED BY LAWRENCE E BOLIND JR, WHO IS AN ATTORNEY.

MY PHONE NUMBER IS 724-695-8620.

DATE September 13, 2013.

EXHIBIT NO. 3B
PAGE: 1 OF 1

Social Security Administration
Please read the Instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Trish Ann Fontana	197 - 56 - 3849
Wage Earner (If Different)	Social Security Number
	- -

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, Lawrence E. Bolind, Jr., Esquire
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is _____
(Name of Principal Representative)

Signature (Claimant)	Address 3130 Glendale Avenue Pittsburgh, PA 15227	
Trish Ann Fontana		
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date
(412) 882 - 0719	( ) -	9-16-13

Part II ACCEPTANCE OF APPOINTMENT

I, Lawrence E. Bolind, Jr., Esquire, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☒ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.

☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☒ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☒ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address 238 Main Street Imperial, PA 15126	
Lawrence E. Bolind, Jr.		
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date
(724) 695 - 8620	(724) 695 - 8621	9-16-13

Part III FEE ARRANGEMENT

(Select an option, sign and date this section.)

☒ **Charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Charging a fee but waiving direct payment** of the fee from withheld past-due benefits —I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Waiving fees and expenses from the claimant and any auxiliary beneficiaries** —By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **Waiving fees from any source** —I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date
Lawrence E. Bolind, Jr.	9-16-13

SOCIAL SECURITY ADMINISTRATION

Refer To: 197-56-3849
Trish Ann Fontana

Office of Disability Adjudication and Review
Suite 2308
1000 Liberty Avenue
Pittsburgh, PA 15222-4023
Tel: (866)331-2291

April 2, 2014

Trish Ann Fontana
3130 Glendale Ave
Pittsburgh, PA 15227

Dear Trish Ann Fontana:

Thank you for your request for a hearing before an administrative law judge (ALJ). This letter explains the hearing process and things that you should do now to get ready for your hearing. We will send you a notice after we schedule your hearing. We will notify you at least 20 days before the date of your hearing. The notice will provide you with the time and place of your hearing. We generally process requests for hearing by date order, with the oldest receiving priority. We will schedule your hearing as soon as we can, which may take several months.

The Hearing

At your hearing, you may present your case to the ALJ who will make the decision on your claim(s). The ALJ will consider the issue(s) you raise, the evidence now in your file, and any additional evidence you provide. The ALJ may also consider other issues, including issues that were decided in your favor in the decision you appealed. The Notice of Hearing will list the issues the ALJ plans to consider at the hearing. In certain situations, we may offer the option of holding your hearing by video conference rather than in person. We will let you know ahead of time if this is the case.

Your hearing is the time to explain why you believe the ALJ should decide the issues in your favor.

Providing Additional Evidence

We need to make sure that your file has everything you want the ALJ to consider and any other evidence the ALJ will need to decide your case. After the ALJ reviews the evidence in your file, he or she may request more evidence to consider at your hearing.

If there is more evidence you want the ALJ to see, please give it to us as soon as possible. Giving us evidence early can often help us review your case sooner. If there is evidence you cannot give to us before the hearing, you may bring it to the hearing.

See Next Page

We can help you get evidence you believe the ALJ should see. If you need help, contact our office, your local Social Security office, or your representative (if you appoint one) immediately.

If a physician, expert, or other person is not providing documents important to your case, you may ask the ALJ to issue a subpoena. A subpoena is a special document that requires a person to submit documents or to testify at your hearing. The ALJ will issue a subpoena only if he or she thinks the evidence is necessary to decide your case, and the evidence cannot be obtained another way. You must ask the ALJ to issue a subpoena at least 5 days before your hearing date. Send your request in writing to the address at the top of the first page of this letter.

You May See The Evidence In Your File

If you wish to see the evidence in your file, you can see it on or before the date of your hearing. If you wish to see your file before the date of your hearing, please call us as soon as you reasonably can at the number at the top of the first page of this letter.

If You Have Any Questions Or Your Address Changes

If you have any questions, please call or write us. You must tell us if you change your address. For your convenience, we gave you our telephone number and address on the first page of this letter.

Sincerely yours,

Julianne Hostovich
Hearing Office Director

Enclosures:
Form SSA-L1697-U3 (Acknowledgement of Representation)
Form HA-L32 (Electronic Disability Claims Processing Insert)
HA-827 (Medical Release Notice)
SSA-827 (Authorization to Disclose Information to SSA)
Barcode Sheet

cc: Lawrence Bolind
238 Main Street
Imperial, PA 15126

SOCIAL SECURITY ADMINISTRATION

Refer To: 197-56-3849
Trish Ann Fontana

Office of Disability Adjudication and Review
Suite 2308
1000 Liberty Avenue
Pittsburgh, PA 15222-4023
Tel: (866)331-2291

April 2, 2014

Trish Ann Fontana
3130 Glendale Ave
Pittsburgh, PA 15227

Dear Trish Ann Fontana:

Thank you for your request for a hearing before an administrative law judge (ALJ). This letter explains the hearing process and things that you should do now to get ready for your hearing. We will send you a notice after we schedule your hearing. We will notify you at least 20 days before the date of your hearing. The notice will provide you with the time and place of your hearing. We generally process requests for hearing by date order, with the oldest receiving priority. We will schedule your hearing as soon as we can, which may take several months.

The Hearing

At your hearing, you may present your case to the ALJ who will make the decision on your claim(s). The ALJ will consider the issue(s) you raise, the evidence now in your file, and any additional evidence you provide. The ALJ may also consider other issues, including issues that were decided in your favor in the decision you appealed. The Notice of Hearing will list the issues the ALJ plans to consider at the hearing. In certain situations, we may offer the option of holding your hearing by video conference rather than in person. We will let you know ahead of time if this is the case.

Your hearing is the time to explain why you believe the ALJ should decide the issues in your favor.

Providing Additional Evidence

We need to make sure that your file has everything you want the ALJ to consider and any other evidence the ALJ will need to decide your case. After the ALJ reviews the evidence in your file, he or she may request more evidence to consider at your hearing.

If there is more evidence you want the ALJ to see, please give it to us as soon as possible. Giving us evidence early can often help us review your case sooner. If there is evidence you cannot give to us before the hearing, you may bring it to the hearing.

See Next Page

We can help you get evidence you believe the ALJ should see. If you need help, contact our office, your local Social Security office, or your representative (if you appoint one) immediately.

If a physician, expert, or other person is not providing documents important to your case, you may ask the ALJ to issue a subpoena. A subpoena is a special document that requires a person to submit documents or to testify at your hearing. The ALJ will issue a subpoena only if he or she thinks the evidence is necessary to decide your case, and the evidence cannot be obtained another way. You must ask the ALJ to issue a subpoena at least 5 days before your hearing date. Send your request in writing to the address at the top of the first page of this letter.

You May See The Evidence In Your File

If you wish to see the evidence in your file, you can see it on or before the date of your hearing. If you wish to see your file before the date of your hearing, please call us as soon as you reasonably can at the number at the top of the first page of this letter.

If You Have Any Questions Or Your Address Changes

If you have any questions, please call or write us. You must tell us if you change your address. For your convenience, we gave you our telephone number and address on the first page of this letter.

Sincerely yours,

Julianne Hostovich
Hearing Office Director

Enclosures:
HA-827 (Medical Release Notice)
SSA-827 (Authorization to Disclose Information to SSA)

cc: Lawrence Bolind
238 Main Street
Imperial, PA 15126

NOTICE TO REPRESENTATIVE OF CLAIMANT BEFORE THE SOCIAL SECURITY ADMINISTRATION

TOE 420

Lawrence Bolind
238 Main Street
Imperial, PA 15126

Date: March 29, 2014

Claimant: Trish Ann Fontana

Wage Earner:

Social Security Number: 197-56-3849

We have received written notice that the claimant has appointed you to act as the representative in connection with this claim(s) under the Social Security Act (the Act). We will, therefore, be dealing directly with you on matters pertaining to this claim(s).

Generally, to charge a fee for services, you must use one of two, mutually exclusive fee approval processes. You must file either a fee petition or a fee agreement with us. In either case, you cannot charge more than the fee amount we approve.

Fee Petition Process

You may ask for approval of a fee by giving us a fee petition when you have completed your services to the claimant. This written request must describe in detail the amount of time you spent on each service provided and the amount of fee you are requesting.

Fee Agreement Process

If you and the claimant have a written fee agreement, that you have not already submitted, either of you must give it to us before we decide the claim(s). We usually will approve the agreement if you both sign it; the fee you agreed on is no more than 25 percent of the past-due benefits, or $6,000 (or a higher amount we set and announce in the Federal Register), whichever is less; we approve the claim(s); and the claim results in past-due benefits.

If you do not file a fee agreement, you must use form **SSA-1560-U5 (PETITION TO OBTAIN APPROVAL OF A FEE FOR REPRESENTING A CLAIMANT BEFORE THE SOCIAL SECURITY ADMINISTRATION)** to petition for approval of the fee you wish to charge. File the SSA-1560-U5 when the proceedings are complete and your services have ended. If you are an attorney or a non-attorney whom SSA has found eligible to receive direct payment and you seek direct payment from the claimant's title II or title XVI past-due benefits, you must file the SSA-1560-U5, or a notice of intent to petition for a fee within 60 days of the notice of the favorable determination. Further information and instructions for completion are given on the form itself.

After we approve a fee, you must look to the claimant for payment, except when you are an attorney or non-attorney who is eligible to receive direct payment and there are past-due benefits payable under title II or title XVI of the Act as a result of a favorable determination on the claim. In such cases, we will pay up to 25 percent of such past-due benefits directly to you toward payment of the approved fee and charge you the assessment required by section 206(d) and 1631(2)(2)(c) of the Social Security Act. You cannot charge or collect this expense from the claimant.

If you wish to waive either a fee or direct payment of a fee and you have not already done so, you should sign and date the appropriate box below or send us a letter with an appropriate statement. Early filing of the waiver will enable us to prevent the automatic withholding of past-due benefits for a possible direct payment.

- **WAIVER OF FEE** - I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligation, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date

- **WAIVER OF DIRECT PAYMENT BY ATTORNEY OR NON-ATTORNEY ELIGIBLE TO RECEIVE DIRECT PAYMENT -** I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Representative)	Date

Social Security Administration

Form **SSA-L1697-U3** (2-2005)

Destroy Prior Editions

Electronic Disability Claims Processing

Social Security is changing from a paper to an electronic disability claims process in order to improve the quality and timeliness of our decisions. Your client's disability claim file is being processed electronically. Your claimant's rights under the Social Security Act remain the same.

When your client's case is exhibited, we will forward a copy of the file to you on a compact disc (CD). We will also provide you a copy of the file on CD on the day of the hearing. Should you require a copy of the file at any other time, please contact the hearing office.

Additional evidence should be submitted within the timeframes for the submission of evidence discussed in the cover letter. **The preferred way to submit evidence to the electronic folder is by using one of the following three methods:**

- **Send the evidence using the Electronic Records Express (ERE) website. If you have not registered to use the ERE website, contact your local hearing office.**

- **Fax the evidence using this fax number -- (877)548-8812. Remember that the enclosed barcode must be the first page for <u>each document</u> being faxed.**

- **Send the evidence to the contract scanner listed below. The barcode must be the first page of each document. DO NOT SEND ORIGINAL DOCUMENTS. DOCUMENTS ARE NOT RETURNED.**

  Pittsburgh, PA ODAR
  P. O. Box 9033
  London, KY 40742-9033

You may also send the evidence by mail or deliver it to the hearing office but there may be a delay in associating the evidence with the electronic file.

NOTE: The attached barcode pertains to your client's disability claim file only. Please keep the original barcode sheet for submitting all documents on this case. Bar codes may be used more than once when faxing evidence into the electronic file.

SOCIAL SECURITY ADMINISTRATION

Refer To: 197-56-3849
Trish Ann Fontana

Office of Disability Adjudication and Review
Suite 2308
1000 Liberty Avenue
Pittsburgh, PA 15222-4023
Tel: (866)331-2291

April 2, 2014

Trish Ann Fontana
3130 Glendale Ave
Pittsburgh, PA 15227

Dear Trish Ann Fontana:

In order to obtain records to update your file we need a current Authorization to Release Information. Please sign the enclosed form(s) and return it to our office within ten (10) days. A return envelope is enclosed for your convenience.

Sincerely,

Julianne Hostovich
Hearing Office Director

cc: Lawrence Bolind
238 Main Street
Imperial, PA 15126

Enclosure (SSA-827)

EXHIBIT NO. 4B
PAGE: 8 OF 10

WHOSE *Records to be Disclosed*	Form Approved OMB No. 0960-0623
NAME *(First, Middle, Last, Suffix)* Trish Ann Fontana	
SSN 197-56-3849	Birthday *(mm/dd/yy)* 06/02/1967

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign
☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address 3130 Glendale Ave		
Phone Number (with area code) (412)882-0719	City Pittsburgh	State PA	ZIP 15227

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

IF needed, second witness sign here (e.g., if signed with "X" above)
SIGN ▶

Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any Social Security office.

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INSERT THIS END FIRST

Please include this barcode cover sheet as the first page of each set of documents returned.

Fax the evidence to this fax number:

(877)548-8812

RQID:00000000000000000128125808 SITE:Y12 DR:S
SSN:197563849 DOCTYPE:5032 RF:D CS:cab

Claimant: Trish Ann Fontana
SSN: 197-56-3849

SOCIAL SECURITY ADMINISTRATION

Refer To:
Trish Ann Fontana

Office of Disability Adjudication and Review
Suite 2308
1000 Liberty Avenue
Pittsburgh, PA 15222-4023
Tel: (866)331-2291

March 29, 2014

Lawrence Bolind
238 Main Street
Imperial, PA 15126

Dear Lawrence Bolind:

The above named claimant has filed a request for a Social Security hearing, and the record shows that you are representing this person.

Proposed exhibits in the above referenced file are now ready for your review. Please log into http://ssa.gov/ar/ to view the proposed exhibits which are shown in the exhibit list tab. Further processing of this case requires the following actions on your part:

1. It is the claimant's responsibility to provide medical evidence showing that he/she has an impairment(s) and how severe it is during the time he or she alleges disability. In order to expedite processing of this claim, you should submit the following information:

    a. All medical records *(not duplicates)* from one year prior to the alleged onset date to the present and any other relevant medical, school or other records not already in file. Please refer to your client's electronic folder to avoid submitting duplicate records.

    b. Completed Recent Medical Treatment, Medications and Work Background questionnaires, and signed Authorization to Release Information (enclosed).

2. Advise us when all relevant evidence is up-to-date and the case is ready to be scheduled.

Please submit all evidence using one of the three electronic methods:

1. Fax using the enclosed barcode to the FECS server number (877)548-8812,
2. ARS (Appointed Representative Services) website or
3. Contract Scanner **(Note: Please do not send original documents directly to the contract scanner as they will not be returned.)**

    Pittsburgh, PA ODAR
    P. O. Box 9033
    London, KY 40742-9033

See Next Page

As soon as you submit the foregoing, we will review your case to determine if we can make a fully favorable decision without holding a hearing. If we cannot make a decision on the record, we will schedule your case for hearing. Therefore, it is to your advantage to submit your evidence as soon as possible.

If you have any questions, please contact the number listed above.

Sincerely,

Julianne Hostovich
Hearing Office Director

Enclosures:
HA-4631 (Claimant's Recent Medical Treatment)
HA-4632 (Claimant's Medications)
HA-4633 (Claimant's Work Background)
SSA-827 (Authorization to Disclose Information to the Social Security Administration (SSA))

cc: Trish Ann Fontana
3130 Glendale Avenue
Pittsburgh, PA 15227

Social Security Administration
Office of Disability Adjudication and Review

Form Approved
OMB No.0960-0292

CLAIMANT'S RECENT MEDICAL TREATMENT

A. To be completed by hearing office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	The last time we brought your case up-to-date was:
Trish Ann Fontana 197-56-3849		September 16, 2013

B. To be completed by claimant

PLEASE PRINT

Please Answer the Following Questions:

(1) Have you been treated or examined by a doctor (other than a doctor at a hospital) since the above date? ☐ Yes ☐ No

(If yes, please list the name, addresses and telephone numbers of doctors who have treated or examined you since the above date. Also list dates of treatment or examination. If possible, send updated reports from these doctors to the Administrative Law Judge prior to the date of your hearing.)

DOCTORS' NAME(S)	ADDRESS(ES) & TELEPHONE NO.(S)	DATE(S)

(2) What have these doctors told you about your condition?

(3) Have you been hospitalized since the above date? ☐ Yes ☐ No

(If yes, please list the name and address of the hospital. Also explain why you were hospitalized and what treatment you received.)

Name of Hospital	Address of Hospital (Include ZIP Code)

Reason for hospitalization:

Treatment received:

Form **HA-4631** (8-1996) ef (6-2009)
Issue Old Stock

If more space is needed, use additional sheets.

RQID:00000000000000001128124486 SITE:Y12 DR:S
SSN:197563849 DOCTYPE:3040 RF:D CS:fa6d

Privacy Act Statement

Collection and Use of Personal Information

Sections 205, 1631(d)(1), and 1872 of the Social Security Act, as amended authorize us to collect this information. We will use this information to evaluate your reason for failing to appear at your scheduled hearing.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the requested information may affect our ability to re-evaluate the decision on your claim.

We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal Laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs as at the Federal, State, and local level; and

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete use of routine uses for this information is available in our Systems of Records Notices, 60-0009, Hearings and Appeals Case Control System, and 60-0010, Hearing Office Tracking System of Claimant Cases. These notices, additional information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at any local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. The OMB control number for this collection is 0960-0292. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

Form **HA-4631** (8-1996) ef (9-2012)

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

Form Approved
OMB No.0960-0289

CLAIMANT'S MEDICATIONS

A. To be completed by Hearing Office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	The last time we brought your case up-to-date was:
Trish Ann Fontana 197-56-3849		September 16, 2013

B. To be completed by the claimant

PLEASE PRINT

PLEASE LIST BELOW THE PRESCRIPTION MEDICATION WHICH YOU ARE PRESENTLY TAKING. IF THE NAME OF THE MEDICATION IS NOT SHOWN ON THE PRESCRIPTION CONTAINER, YOU MAY VERIFY THE NAME WITH YOUR PHARMACIST.

NAME OF MEDICATION & DOSAGE	DATE FIRST PRESCRIBED	DAILY AMOUNT TAKEN	REASONS FOR MEDICATION	NAME OF PHYSICIAN

PLEASE LIST BELOW THE NONPRESCRIPTION MEDICATION YOU ARE TAKING AND THE REASONS YOU TAKE THEM.

Form **HA-4632** (2-1994) ef (6-2009)
Use Until Stock Is Exhausted

RQID:00000000000000001281244487 SITE:Y12 DR:S
SSN:197563849 DOCTYPE:3045 RF:D CS:eebb

If more space is needed, use additional sheets.

Privacy Act Statement

Collection and Use of Personal Information

Sections 205, 1631(d)(1), and 1872 of the Social Security Act, as amended authorize us to collect this information. We will use this information to evaluate your reason for failing to appear at your scheduled hearing.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the requested information may affect our ability to re-evaluate the decision on your claim.

We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal Laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs as at the Federal, State, and local level; and

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

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Form **HA-4632** (2-1994) ef (9-2012)

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

Form Approved
OMB No.0960-0300

CLAIMANT'S WORK BACKGROUND

A. To be completed by Hearing Office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	The last time we brought your case up-to-date was:
Trish Ann Fontana 197-56-3849		September 16, 2013

B. To be completed by the claimant

PLEASE PRINT

Start with your most recent job, and list that and any work performed within the past 15 years.

DATE OF EMPLOYMENT (APPROXIMATELY)	NAME OF EMPLOYER AND LOCATION OF EMPLOYMENT	DUTIES PERFORMED
FROM		
TO		
FROM		
TO		
FROM		
TO		

Form **HA-4633** (3-1994) ef (6-2009)
Issue Old Stock

If more space is needed, use additional sheets.

RQID:00000000000000000128124489 SITE:Y12 DR:S
SSN:197563849 DOCTYPE:3050 RF:D CS:2851

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 702, 1631 (e)(1)(A) and (B) and 1869(b)(1)(C) of the Social Security Act, as appropriate, authorize us to collect the information on this form. The information you provide will help us to determine your potential eligibility for benefit payments and/or help us to decide if additional information is needed. Your response is voluntary. However, failure to provide the requested information may prevent an accurate and timely decision on any claim filed, or could result in the loss of benefits.

We rarely use the information provided on this form for any purpose other than for determining entitlement to benefit payments. In accordance with 5 U.S.C. § 552a(b) of the Privacy Act, however, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state and local level;

3. To comply with Federal laws requiring the disclosure of the information from our records; and

4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs. The law allows us to do this even if you do not agree to it.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

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Form **HA-4633** (3-1994) ef (6-2009)

WHOSE *Records to be Disclosed*	Form Approved OMB No. 0960-0623
NAME *(First, Middle, Last, Suffix)* Trish Ann Fontana	
SSN 197-56-3849	Birthday *(mm/dd/yy)* 06/02/1967

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** ***including*****, and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address 3130 Glendale Avenue		
Phone Number (with area code) (412)882-0719	City Pittsburgh	State PA	ZIP 15227

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

IF needed, second witness sign here (e.g., if signed with "X" above) **SIGN** ▶

Phone Number (or Address)	Phone Number (or Address)

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Fax the evidence to this fax number:

(877)548-8812

RQID:00000000000000000128124490 SITE:Y12 DR:S
SSN:197563849 DOCTYPE:5032 RF:D CS:afa5

Claimant: Trish Ann Fontana
SSN: 197-56-3849